TITLE Reflections on a field across time and space: the emergent medical and health humanities in South Africa

ABSTRACT

In this paper we draw on our own cross-cultural experience of engaging with different incarnations of the medical and health humanities (MHH) in the UK and South Africa to reflect upon what is distinct and the same about MHH in these locations. MHH spaces, whether departments, programmes or networks, have espoused a common critique of biomedical dualism and reductionism, a celebration of qualitative evidence, and the value of visual and performative arts for their research, therapeutic, and transformative social potential. However, there have also been differences, and importantly a different 'identity' among some leading South African scholars and practitioners, who have felt that if MHH were to speak from the South as opposed to the North, they would say something quite different. We seek to contextualise our personal reflections on the development of the field in South Africa over recent years within wider debates about MHH in the context of South African academia and practice, drawing in part on interviews conducted by one of the authors with South African researchers and practitioners and our own reflections as 'Northerners' in the 'South'.

KEYWORDS: South Africa, Global Medical Humanities, Critical Medical Humanities, Health Humanities, Arts-in-health, interdisciplinarity

MOBILE BIOGRAPHICAL REFLECTIONS

Disciplines evolve differently in different places. Schools of thought emerge and are replaced. Local histories shape priorities and ideologies. With the increasing tendency for academics to not only visit, but to work in institutions far from their alma maters, opportunities arise for thinking through how fields or disciplines emerge and transform across time and space from a first-person perspective. This is the crux of this article. Here we draw together a series of observations about work in the medical humanities in quite different geographic and socioeconomic spheres: namely the UK and South Africa. We also document – from our subjective perspectives – some of the key events in the early stages of the emergence of MHH in South

Africa. We make no claims to comprehensiveness, or the universal applicability of these observations. This is more in the nature of a description of what we have each encountered. We draw on our own experiences, as well as more formal interviews [author 1] has undertaken with colleagues in South Africa,[1] and wider literature. Given that we are attempting to discuss geographically and academically specific developments, it is apt first to situate ourselves in this matrix.

[author 2] studied Anthropology and Social Studies of Medicine as an undergraduate in Canada, and worked as a research assistant in a teaching and research unit promoting Whole Person Care between 2003 and 2008. From 2008-2013 she lived in the UK, where she completed a Masters and PhD in medical anthropology. During her postgraduate studies she was a teaching assistant in the medical school and a member of the Postgraduate research group in medical humanities. She later took up work as a postdoctoral research associate in a UK Centre for Medical Humanities before moving to South Africa to undertake a Postdoctoral Fellowship in Social and Behavioural Sciences in a Faculty of Health Sciences (2014-2018). In South Africa she became involved in the development of the Medical and Health Humanities Network Africa.

[author 1] returned to the academy to study a Masters in Health Communication and Music after 15 years of professional experience associated with the arts-in-health movement in the UK. As an arts manager in National Health Service (UK) hospitals she commissioned artists and art therapists to work in a variety of ways in clinical spaces. As a composer she combines music with narrative research to explore health and medicine.[2] Since moving to South Africa in 2014, she has continued to do arts-in-health work but has fallen instead under the parabola of the 'community arts' or 'medical humanities'. She has worked as a project manager, sessional lecturer and research associate with a Mellon-funded medical humanities programme at [removed for blind review].

THE EMERGENCE OF MEDICAL AND HEALTH HUMANITIES IN SOUTH AFRICA: THE CHALLENGES OF DEFINITION

[1] **"**Ten questions about the medical and health humanities in South and southern Africa": http://medicalandhealthhumanitiesafrica.wordpress.com/interviews

[2] See removed for blind review]

We, the authors, had met briefly at a medical humanities conference in the UK in 2008 and then serendipitously arrived in South Africa the same year, joining [university and city names removed for blind review]. We arrived in 2014, when the second Medical Humanities in Africa conference was being organised, and from different sides of South Africa became involved in the organisation of the conference and the activities of the emergent network.

This network was led by a small group (referred to henceforth as 'the founding network') of academics across three universities. The group included the founder of the medical humanities research programme at WISER (an historian), the creators of the Medicine and the Arts postgraduate course at the University of Cape Town (an anthropologist and a physician), the founder of the Division of Social and Behavioural Sciences in the School of Public Health and Family Medicine at University of Cape Town (an anthropologist), and the co-founder of the Transdisciplinary Health and Development Studies programme at Stellenbosch University (also an anthropologist). Later the founding network was joined by us and others to form a loose affiliation of 10 or so people (many of whom are authors in this special issue). The early progress of this work is thoroughly documented in Reid (2014).[1]

While in the US the first formally named Medical Humanities unit was created in 1973,[1] with the UK pushing the idea forward in the late 1990s and early 2000s,[2,3] in South Africa the medical humanities was recognised as a "new knowledge field" by the South African National Research Foundation (NRF) as recently as 2013; and the first (and still only) Lecturer in Medical Humanities was appointed in the Primary Care Directorate of the Faculty of Health Sciences at the University of Cape Town in late 2014. Recent key medical humanities texts (the 2016 *Edinburgh Companion to the Critical Medical Humanities* and the 2015 *Health Humanities Reader* amongst them) favour authors from and based in the UK and US, suggesting that these academic networks have not yet expanded as far as they aspire to.[3] South Africa – indeed Africa and arguably the 'South' more generally – has not thus far been a prominent player in the development of this

[3] The irony of our own positioning as two hybrid northern scholars currently based in the south is not lost on us and we acknowledge the generosity of our African colleagues in allowing us to make this point.

area of thought, something Woods and Whitehead address in their Introduction to the *Edinburgh Companion*.[3, pp6-7]

The imperative to consider MHH in South Africa, then, stemmed partly from a sense that the MHH were already being enacted across Africa, if called by other names (medical anthropology, applied arts etc.) and that MHH could help us usefully pull together these disparate projects to support each other at a time of scholarly zeitgeist around MHH, with new funding streams appearing. A pragmatic impetus for the MHH initiative in SA is the potential funding the MHH name brings for cross-dicsiplinary research that is otherwise hard to come by. Indeed, the development of the MHH in South Africa has been dependent on two grants: from the NRF in 2013[1] and the Mellon Foundation in 2014.[4] Subsequent efforts such as this SI will we hope allow scholars and practitioners in Africa to recognise themselves in the MHH literature in a way that has perhaps not thus far been the case.

A second imperative was the prospect of the tools the MHH could offer for unpacking some of the problematics of medicine in African contexts. Burns for example talks about the importance of deconstructing the "process of medicalisation in Southern Africa" and the "ritualised passivity" that is one consequence of this colonialising process, epitomised for her by the trope of the waiting room.[4, np] There is also, however, the more urgent question of decolonisation – and its relationship with trans- and interdisciplinarity. For Mbembe,

> To decolonize the university is therefore to reform it with the aim of creating a less provincial and more open critical cosmopolitan pluriversalism – a task that involves the radical re-founding of our ways of thinking and a *transcendence of our disciplinary divisions*.[5, np, italics added]

Mbembe also cites Fanon's "call to 'provincialize' Europe; to turn our backs on Europe; to not take Europe as a model". There is of course an inherent problem here, inasmuch as MHH is a concept no more separate from European scholarship than biomedicine itself. Indeed, Hooker and Noonan, in this journal, contend that "medical humanities as a field has often been strongly, although not wholly, reflective of the traditions of Western (Anglo-American and European) culture, particularly what used to be referred to as 'high'

[4] https://wiser.wits.ac.za/medical-humanities.

culture".[6, p79] It remains problematic for SA to take up the emblem of MHH, but we must also consider Ngugi, who (as Mbembe sees it) suggests both that the Western intellectual tradition *can undo itself*, and that it is, to an extent inherently more *African* than is often understood:

> The Western archive is singularly complex. It contains within itself the resources of its own refutation. It is neither monolithic, nor the exclusive property of the West. Africa and its diaspora decisively contributed to its making and should legitimately make foundational claims on it.[5,np]

MHH must be taken on board with the knowledge that, as Hooker and Noonan put it, "since Western cultural traditions embody certain ideas about selfhood, patienthood, illness and medical care, the dominance of these traditions may exclude important ways of knowing and being for both Western and non-Western patients and doctors"[6, p79] – and cognisant too of the fact that MHH (particularly critical MHH) may to an extent be an attempt at the refutation of its own Western archive.

For Ngugi (again quoted in Mbembe[5,np]), Africa has to be placed at the centre. "Education is a means of knowledge about ourselves … After we have examined ourselves, we radiate outwards and discover peoples and worlds around us. With Africa at the centre of things, not existing as an appendix or a satellite of other countries and literatures, things must be seen from the African perspective". This re-centring was a driving force behind the NRF grant that helped to 'found' MHH in South Africa and "aimed at defining exactly what we mean by the term in the SA context, and at expanding our networks to include scholars working in other countries in Africa".[1, p110]

As Reid puts it, "Rather than defaulting to the North American and European definitions and understandings of medical humanities, it seems important to explore the field within our own SA cultural, historic, geographical and political context".[1, p110] The ongoing struggle against the restrictions of how the medical humanities are conceptualised and practiced in the North haunts all attempts at definition within the MHHA network, and creates an anxiety about theoretical bases. For example, a participant at a recent MHHA meeting raised the question of why we are still quoting Foucault, not Mbembe and Fanon. Indeed, these theorists engage similar philosophical questions (e.g the subject, power) and others' careful analysis has teased out some of their complex similarities and differences.[7,8] What our colleague's

question points to is a tendency to read (and later cite) the European author when in fact others' philosophies 'speak from the South' more clearly in their emphasis on colonialism, race and class. Here we use the terms 'North' and 'South' because they are terms we have so often heard used in the SA space – themselves set against a backdrop of social and student movements calling for decolonisation of knowledge and pedagogy (see Pentecost et al. in this issue for more on this question[9]). The meaning we intend by 'North' and 'South' here is reflected in Levander and Mignolo's description:

> The "Global South" is not an existing entity to be described by different disciplines, but an entity that has been invented in the struggle and conflicts between imperial global domination and emancipatory and decolonial forces that do not acquiesce with global designs. Thus, it is well known – to start with – that "Global South" is the geopolitical concept replacing "Third World" after the collapse of the Soviet Union. From this perspective, the global south is the location of underdevelopment and emerging nations that needs the "support" of the global north (G7, IMF, World Bank, and the like). However, from the perspective of the inhabitants (and we say consciously inhabitants rather than "citizens," regional or global), the "Global South" is the location where new visions of the future are emerging and where the global political and decolonial society is at work.[10,p3]

We quote this fully aware of the irony that this paper is written by two hybrid 'Northern' scholars living in the 'South'. And indeed of a related representational issue inherent in naming a network initiated by South African scholars Medical and Health Humanities *Africa*. The network's members are conscious of the fact that its pan-African intent is for now more aspiration than reality, and – as our colleagues in this special issue have pointed out – there are important discussions to be had about South Africa's capacity in any way to represent Africa, given its in some ways continentally anomalous history and global position. Such discussions are, however, beyond the scope of this article.

In the interests of continuing these discussions of the meaning of MHH for South Africa and broadening the group involved in them, after two national conferences, the founding network and more recent arrivals like ourselves decided at a retreat to formalise the network. With a view to expanding the network with our colleagues across the continent, we settled on the name Medical & Health Humanities Africa (MHHA). Along with many other scholars who contribute to the ongoing debates about naming (e.g. [11,12]), we felt that 'health' broadened the focus out from biomedicine and towards wellbeing. Carla Tsampiras refers in her interview for the MHHA network website as "a *massive* overfocus on *medicine* …

often at the expense of other health sciences, and of other healing modalities". This restricted view has particular implications in a context like SA, where other healing modalities may include local traditions that have been systematically sidelined (see e.g. [13]).[5]

The network currently operates predominantly through a website and a newsletter acting as a hub for the dissemination of relevant works, debates and conferences. The website also hosts an ongoing series of interviews with people who either describe their work as medical humanities, or whose work elides with this area in some way: a music therapist, a health communications researcher, a theologian interested in definitions of 'care', a political scientist focused on epidemics, and so on.[6] The anthropological/historical character of the founding network remains, but the network now includes subscribers from a wide range of disciplines – including for example artists, clinicians, and literary scholars. Beyond agreeing on the name, however, the network's ongoing discussions suggest that no member of this loose and widening group has a definitive idea of what MHH might *be*. The network has thus far shied away from the kind of humanist "mission statement" that Hooker and Noonan identify[6] and which might be equated with the "service model" Viney et al.[14] seek to move past. MHH conjures up a huge range of ideas in the members of the MHHA (ideas which evolve each time we meet). Some are very arts-oriented.[15] Some lean towards social science, or participatory action research.[16] Some are oriented to medical education;[17] some public health.[18] Some are heavily engaged with anthropology, history, literature. Some tend more toward engaged activism (pragmatic challenges to health systems), some more toward theorising new spaces (philosophical challenges). All of these themselves reflect different ancestries within the existing medical and health humanities literature.[2,3] Indeed MHH in South Africa is thus far characterised by the same heterodoxy many have identified in other locations[e.g. 14,19], and is less a discipline than a field constituted of ideas and projects. As Whitehead and Woods put it, research in this field is often defined by "heterogeneous and partial positions and practices".[3,p8] Erica Penfold (formerly a Research Fellow with the South African Institute of International Affairs) echoes this in an interview for the MHHA: "It's not a

[6] http://medicalandhealthhumanitiesafrica.wordpress.com/interviews

catchall, it's a point of understanding between fields". MHH is made manifest on a project-by-project basis, as (for Penfold) "a position where you can come together in a similar space and learn from each other in that space. Instead of having clinician language, anthropologist language, IR [International Relations] language".[7] In this model, scholars and practitioners can drift in and out of MHH. It requires no lifelong disciplinary commitment, but more an openness to the disciplinary commitments of others. In her interview, Carla Tsampiras, senior lecturer in medical humanities at the University of Cape Town, describes the space as one in which we are "bringing a disciplinary skill, but thinking about moving outside of the confines of a particular discipline".

Carla Tsampiras notes in her interview that MHH in SA "became a way for people to find other people who had similar experiences to create some sort of space where outliers and outsiders could get together to talk about a thing that was held to together by a shared interest, even if the practice of that was completely different". This lack of definition can, however, create an anxiety that [author 1] has witnessed variously in the UK, (briefly) Norway and South Africa – where those engaging in MHH often wonder whether they belong. The openness can be intimidating if one is unused to multidisciplinarity, and can be offputting to the very people who should be taking these thoughts forward, who secede to louder, more confident voices. It can be especially hard, we have observed, for clinicians to enter into this space and to acclimatise to academic language. Furthermore, over a decade after Evans, our impression is that his "cautionary note", below, may be worth considering in the South African context.

> The benefits of intellectual creativity that such a diversity of individuals in theory offers may be offset by the adverse impact of too many varying influences upon a field of enquiry that is not yet itself sufficiently mature to be entirely confident of its own general nature, still less its detailed identity and purposes.[20,p366]

Yet Pattinson urges those interested in the MHH to resist the closing down of this experimental space, referring to healthcare ethics as a salutary example: "As it becomes increasingly coherent, lapidary, smooth, and self confident, it is in danger of eliminating all loose ends and radically different approaches to the big

[7] http://medicalandhealthhumanitiesafrica.wordpress.com/interviews

questions and issues of life".[19,p.35] Indeed our concern for closure, and the defining of things is perhaps symptomatic of the inability to speak across difference that, recalling Mbembe, above, may be identified with colonial intellectual practice – as well as a lack of what Carla Tsampiras (after fellow historian of medicine Catherine Burns) calls in her interview "disciplinary generosity". In their assertion of a *critical* medical humanities, Viney et al. develop this into a sense of "entanglement" amongst disciplines, rather than a desire for one to act upon another.[14] Their espousal of experiment was echoed strongly by the MHHA network meeting in September 2015, in which attendees decided that we should be led by the notions of "rigorous improvisation" and "disciplined curiosity".[8]

Yet the imperative to *contain* MHH in South Africa remains significant. Without more precise definition, the network is vulnerable to the whims of funders, and to the fluctuating energies of individuals. It may be hard for those involved to stay motivated and committed to moving the network forward. At this emergent stage, MHH is happening at the borders of our professional lives; barring the NRF and Mellon grants, funding is project-based; such projects often demand more energy than they create. From our knowledge of big MHH projects in the UK, the need for dedicated core support is unquestionable if the network is to grow. For if the still-nascent MHHA network is inspiring a certain amount of interest amongst those it reaches, "reach" is the key term here when it comes to work scattered across the vast geo-political, multilingual spectrum of Africa, and the numbers of people confidently espousing the field remain few – we are far from a critical mass or any kind of tipping point. Resource pressures and constrictions on access to expensive Northern literature, too, slow our progress. Political instability is a double-edged sword in this context, however. The recent #FeesMustFall movement in SA, for example, took logistical energy away from the MHHA network: for many, improvisatory energies were directed at the university itself and working in the interest of students' and colleagues' immediate and future welfare, not forging new relationships and 'projects' for funding. Yet in the longer term, the reenergised push for decolonisation may help us forge our arguments for the need for an MHH of the South.

[8] Minutes of the MHHA network meeting, September 2015.

As is well known, South Africa is one of the most unequal countries in the world. In 2016, 10% of the population owned 90–95% of all assets.[9] While the state sector provides health care for 80% of the population, it accounts for under half of total healthcare spending,[21] a problem that overwhelmingly falls at the feet of black and mixed-race South Africans, 81% and 63% of whom (respectively) use public sector health facilities.[22,np] Given the resource and political contexts of this work, what is perhaps surprising is the traction MHH *does* have in South Africa. Giskin Day, a UK medical humanities lecturer, describes perceptions of MHH as a "luxury" in the curriculum.[10] If MHH is seen as a luxury in the UK, one might expect clinicians in the resource-starved South African state healthcare system to dismiss the humanities entirely. Yet it is the very pragmatism of resource-pressured clinical care that is allowing the humanities into clinical spaces. The peak of the HIV/AIDS crisis was broken by a multi-disciplinary effort: by politics, law and public art as much as by medicine.[23-28] Moreover the arts – in particular South Africa's rich tradition of theatre-making and its affiliation with the radical pedagogic principles of Boal – continue to play a massive role in health education and broader social development.[11]

Health practitioners are made aware on a moment-by-moment basis of the limitations of the clinical setting, of the need to draw on resources from outside medicine to tackle health issues which are self-evidently inseparable from socio-economics, gender, politics and law. In his Reith Lectures series for the BBC, Atul Gawande talks about "The Century of the System" in medicine, emphasising the absolute necessity for multidisciplinary teamwork in a situation where "the volume of knowledge and skill has exceeded our individual capabilities".[29] His example is one in which a single life is saved (in the US) against extraordinary odds by a complex, synchronous hospital team. In South Africa, the sheer volume of need competes with the biomedical and technological advances Gawande describes, and makes the broader "system" around interventions all the more obviously the driver of health. Questions of access, inclusion and social justice are

[9] See https://www.thesouthafrican.com/inequality-increase-apartheid-south-africa/ and https://theconversation.com/south-africa-needs-to-fix-its-dangerously-wide-wealth-gap-66355.
[10] http://medicalandhealthhumanitiesafrica.wordpress.com/interviews
[11] See a 2014 MHHA interview with Theatre and Health specialist Emma Durden, available at https://artshealthsouthafrica.wordpress.com/2014/09/08/something-like-82-of-the-audience-went-for-hiv-testing-within-a-week-of-having-watched-the-theatre-piece/.

writ large in every clinical interaction, or indeed non-interaction.[30] The HIV/AIDS crisis arguably brought into sharp focus the psychosocial nature of health, something apparent too in the growing crisis of noncommunicable disease in SA (see e.g.[31]). As Dhammamegha Annie Leatt puts it in her interview, when it comes to chronic disease, "there's such a limited set of things that can be done [by medicine alone], because there's so many behavioural, psychic, embodied things that go on in that territory that are not amenable to a clinical practice that is based around giving pills and/or prescriptions".

Moreover, it should be acknowledged that although the *density* of MHH in South Africa may be a decade and a half "behind" the UK, this is *not* 2001, and the MHH themselves have moved on. MHH thought and activity in South Africa is emerging into a more confident, critical space. Indeed the critical shift in the medical humanities (see e.g. [3],[14]) may have prepared the ground for some success in South Africa, where from an academic perspective the push to produce theory from Africa, and to challenge the hegemony of Northern scholarship is immense,[32] and where we may be able to help "re-envisage the scene".[3,p2]

BETWEEN THEORY AND PRACTICE

Although Bleakley and Jones[2,p281] suggest a generative relationship between the art therapies and MHH from as far back as the 1940s, and despite the call by Viney et al.[14, p2] for an "entanglement" of biomedicine and the humanities, divides between practitioners (of both the arts and medicine) and scholars still surface in MHH in both the UK and SA. This has some relation to the ways in which people physically gather to develop a field. The world of conferences that drives the spread of academic knowledge, as well as the physical movement of scholars around the world, is foreign to most practitioners. Relevant though it might be, few community healthcare workers, for example, would attend international conferences on public health; few hospital artists-in-residence would attend a gathering of medical anthropologists. The mechanisms of institutional funding, subsidy for travel etc., as well as the networks via which information is passed, mean that only researchers regularly attend these gatherings, occasionally bringing a 'guest' in the guise of an artist, or social worker, or person with lived experience of whatever condition forms the focus of the conference. Crudely, academic conferences are a little like a Gentleman's Club. Non-academics may

attend, but they will always need someone else to buy them drinks at the bar. To address this, conferences in both the UK and SA have begun to offer bursaries to practitioners without institutional backing – a practice we suggest is crucial for the development of the MHH.

Beyond this practical step, however, there is no escaping the fact that the scholar's imperative to publish is different from the practitioner's imperative to produce immediately tangible outcomes. But even *within* the research community there may be a divide of which we should be wary, between (very broadly) those concerned with the development of theory, and those engaged in research that seeks directly and immediately to impact health systems – through Participatory Action Research, for example. The shift towards critical MHH has pulled some of the momentum away from this applied work in the UK – and is matched in SA by the need for theory from the South. Thus, in one MHHA-network discussion about what we thought might be different about the MHH in Africa, [author 2] hypothesised that the multilingualism, multiethnicities and stark inequalities of South African society might be a productive zone for impulse and creativity in approaches to discussing, approaching and raising awareness about health issues, compared to other contexts. The response from one of the South African scholars was that Africa is always associated with practice and very rarely with ideas – i.e. theory, and this is what they want to change. Although universities in SA at first glance seem to have a much stronger emphasis on community engagement, locally-relevant research and social responsiveness than those in the UK, the imperative to 'publish or perish' is all the more freighted with expectationin SA.

INTERDISCIPLINARITY AND PUBLICATION

If MHH are in essence about multidisciplinarity, then multidisciplinary publication would seem to be the one way forward. Yet this remains rare. One issue is the practical business of the Journal Impact Factor. The *BMJ* has a Journal Impact Factor (JIF) of 19.967; *Sociology of Health* 1.89; Medical Anthropology 1.348; *The Journal of Arts & Health* a mere 0.649. As Rushforth and de Rijcke make clear, the relationship between JIFs and actual transmission of knowledge is far from clear; despite this, as they explain, it has come to stand in for more qualitative understandings of the transmission of knowledge and wields enormous power over both institutions and individuals, determining everything from funding allocation to promotion

opportunities.[33] Rushforth and de Rijcke focus their attention on the "folk theories" of medical researchers in relation to JIFs, and indeed the humanities largely give JIFs less credit than medicine, but this surely reduces the incentive for clinical researchers to publish outside the clinical space,[33] while for social science researchers, striving to publish for a medical audience may involve demoting their 'empirical' research to a 'comment' or an 'essay' in a medical journal. Writing collaboratively also implies, in the South African context, sharing the government subsidy paid out for publications. Each publication is a 'unit' and if all the authors are from the same institution the institution receives the flat rate for the 'unit'. If authors are from different institutions, the subsidy is split between them. In some ways, this gives the single-authored paper (highly prized in some social science and humanities and rare in biomedical science) a high value at the departmental level and symbolically at least disincentivises collaborative writing. Linked to the notion of impact factor is the fact that only papers published in journals on the SA Department of Higher Education and Training (DHET)'s list of 'accredited journals' are eligible for the subsidy.

Returning to the issue of 'knowledge', it is clear that clinical knowledge (in particular clinical knowledge that can be assigned a market value) has more fiscal and political power than humanities knowledge. The humanities' credibility remains low in the realm of quantitative knowledge. For Kalitzkus and Matthieson, one thrust of the narrative medicine movement in 2009 was to give credibility to "narratives derived from medical practice and patient encounters [as] a source of knowledge for evidence, beyond the gold standard of randomized controlled trials of evidence-based medicine".[34,p80] Yet progress towards *any* qualitative understanding and evaluation of health (let alone narrative) is hampered both by traditionally quantitative conceptions of medicine and their relationship with a questionable objectivity, and by the financial mores of the health industry (see e.g. [35]). A SA medical student, for example, recently approached [author 1] for advice on creating a small study for her degree, using yes/no questionnaires to assess the impact of recorded music during a minor hospital procedure. It is a model with numerous precedents in clinical literature, and yet she battled long and hard to get this research past her supervisor since it was perceived as "too qualitative". Reflecting this ongoing suspicion, [author 1]'s experience

suggests an implicit hierarchy of research at work – in terms of money, public credibility, and political influence (Figure 1).

- Insert Figure 1 here -

Figure 1: A suggested hierarchy of research based on the authors' experience.

This hierarchal problem is clearly emblematic of wider social structures. As Mbembe argues more broadly, "the frenzied codification of social life according to norms, categories, and numbers" is defining of "the neoliberal moment"[36,p3] and inevitably impacts the power-balance between scholars across these fields. And the feminisation of the associated fields using these methods, as you descend the hierarchy, also reflects larger gender inequalities. Yet the humanities retain their own power in their adherence (for example) to complex and highly sophisticated, discipline-specific language. This difficulty with language is sometimes addressed during MHHA meetings, and also came up at a small international MHH gathering [author 1] attended in 2016 (with South African, British, Eastern European and Scandinavian researchers). A clinician in the room pointed out that although medicine is still criticised for its high-handed use of acronyms and clinical language, in reality clinical education has for some time acknowledged the problems of terminology, and physicians have adjusted their language accordingly. The humanities have had to make fewer concessions to communication outside their field. Overcoming the fear of the terms that have built these disciplines takes time and energy, and a degree of obstinacy. [Author 1]'s early experience of this in SA (as a practitioner returning to academia) was deeply intimidating; and a surprising number of highly successful clinicians have, in our experience, been similarly silenced in such gatherings by the inaccessibility of 'humanities-speak'.

In such a climate, to leave the safety of one's own territory and make incursions into another requires a degree of emotional commitment and time. And indeed, these cross-disciplinary writing is hard work. Differences in style, language, length of manuscript and expected timelines for producing papers, are difficult to reconcile. The difference in writing process between qualitative and quantitative traditions are an especially important barrier to interdisciplinary writing. For example the process of writing articles in law,

humanities, anthropology, history is part of the research process (one is doing the analysis in the process of writing). However, in the scientific tradition, writing is the process of putting the results of an analysis (produced separately) down on paper. Even when one is working alone (for example as a lone ethnographer), straddling the mother discipline (e.g. medical anthropology), the health sciences and medical humanities means writing very different kinds of papers for different kinds of audiences. This can be time consuming and challenging, especially for early career researchers who in our experience are torn between producing outputs that are accessible to clinical audiences, and contributing to their disciplinary literature. The latter continues to be what is needed to prove one's expertise in a given 'field'.

Even beyond the question of publication, as Pattinson puts it, "Retaining breadth, different interests, and interdisciplinary networking will be demanding, costly, time consuming, frustrating, and sometimes conflict ridden".[19,p36] The realisation that our motivations and agendas are different can often come late in the game, and can be deeply disruptive. In our experience this pressure is increased where the context of MHH is less established, where its rules are less well-formed and its funding more precarious. Of the six cross-disciplinary projects [author 1] has worked on in SA, one has collapsed under this weight, while another has limped across the finish line with a distribution of valuable if initially somewhat bruising experiences. We may know how important it is to be clear about respective roles, but these are messy collaborations on the fringes of our disciplines. Crucially, *not to* collaborate is unlikely to result in a negative impact on one's career within a particular discipline – collaboration can at times hold one back, take time away from publishing, and exhaust limited resources. The MHHA has tried to mitigate these challenges by actively sharing resources. For example, by pooling funds and making venues available for the collaborative work that has enabled this special issue.

CONCLUSION

Looking back at our experiences in SA and the UK, it seems that MHH in SA is starting from an immediately more critical position than its northern counterpart. As – for now – an outlier in the global development of MHH, it mimics its advocates, and we suspect it can make its greatest contributions through taking the reins of the emergent movement of critical MHH. We note that the development of this 'space' in South Africa

may run into similar choppy waters encountered in the UK at (perhaps) an earlier phase – potentially adversarial relationships between theorist and activists, enormous collaborative publishing challenges, and a project-by-project cycle of perpetual financial uncertainty. However, MHH in SA also derives its energy from the same heterogeneity as its UK counterpart – as a bric-a-brac of interdiscplinary research and practice embracing the arts, education, and the development of theory. This youthful flexibility transforms into generosity and creativity in its partnerships, and may also ensure that MHH in SA can keep pace with the larger questions of decolonisation, and can find its feet in the "pluriversity" of the future.

A NOTE FROM THE AUTHORS

Writing about one's own experiences, feelings and perceptions can be an uncomfortable space, not only in transgressing the norms of academic writing and one's disciplinary boundaries but also bringing one's own privilege into question.[37] We have been privileged with the economic circumstances, families and careers that enable such mobility. We are aware of the contradictions and potential for a neo-colonial gaze inherent in an exercise of 'northerners' commenting on a movement from the South. We humbly present these reflections as our own and we thank our South African colleagues for their encouragement of these expressions. Our experiences in the North with medical humanities were welcomed for what they could bring to discussions and we are grateful to our colleagues in South Africa for the opportunity to participate so fully.

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